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The Medical Journal of Australia.

SATURDAY, FEBRUARY 17, 1917.

An Urgent Call.

We have been informed officially that the authorities abroad have appealed for a large number of medical officers to be sent out at once, in addition to regular drafts to be supplied at intervals throughout the year. As the men are required chiefly for field ambulance and clearing station work, energy and good physical condition are essential. These men are wanted in addition to those who can be sent out to relieve medical officers who have served for two years or more and who are in need of a rest. Drafts will be sent forward as the men are available, but it is essential that a sufficient number of practitioners should be kept in reserve to serve on transports and other ships leaving these shores for some months to come.

The medical profession is given an opportunity to show its loyalty to the King and the Empire. The community of Australia as a whole has failed to demonstrate this spirit. The authorities asked for 16,500 men each month, which is equivalent to one man out of every 300 individuals of the population. The medical profession is asked to do more. Its younger members are asked to make a great sacrifice. Some readjustment may be necessary before a sufficient number can be liberated from civil practice. Unfortunately a complete organization of the profession has not yet been achieved, but it is not excluded that the readjustment may be effected by the keen men themselves. Every medical practitioner in the Commonwealth should ask himself the question: Have I the necessary qualifications for the positions which the military authorities are seeking to have filled? If the silent reply is in the affirmative, he should enquire of himself and his colleagues whether the civil community in the district where he is practising can be looked after by men who are less suited than he to go to the front. If it be just possible for him to offer his services, he should not hesitate, for his services are required, and he has no right to hold back for personal reasons. He should remember that the number of suitable men is limited, and bring himself to regard the call as one directed personally and especially to himself. We do not doubt that the medical profession will rise to the occasion, and will demonstrate to the community that it can recognize its duty and can obey duty's call.

FRIEDREICH'S ATAXIA.

The accurate, skilled and thorough records of a case of Friedreich's ataxia, by Drs. Litchfield, Latham and Campbell, which are published in the current issue, should be taken as a pattern by practitioners who aim at promoting knowledge by their contributions to the literature of special diseases. The authors are to be congratulated on this production, more especially because it contains all the essential details for an understanding of the clinical and pathological peculiarities of a highly interesting case and an ample discussion of the mode of production of the lesions discovered. The case described is singularly suited for study, because while the characteristics of Friedreich's ataxia are plainly present both in the clinical manifestations and in the post-mortem changes, the pathological picture differs sufficiently from that usually included in classical or text-book descriptions to emphasize the point on which Dr. Campbell lays some stress, namely, the variability of the extent of the recent and of the old-standing morbid processes. The presence of an acute degeneration involving individual fibres side by side with a well-marked sclerosis implicating the greater part but not the whole of the posterior columns and parts of the dorso-lateral columns suffices to put out of court any theory that this condition is dependent on an inherited developmental defect of one or more tracts or systems. Dr. Campbell refers to the views put forward by Gowers and by Newton Pitt, that this condition represents an inherited tendency to early degeneration—according to the former of the nerve tissue involved, and according to the latter of the vessels supplying these tissues. The view which Dr. Campbell favours does not take into consideration

an inherited defect, save in so far as a possible limited capacity of the blood vessels forming the posterior spinal system is concerned. Dr. John Flynn urged that the inheritance factor should not be left out of count, and spoke of the distinction between family and hereditary diseases. We are indebted to Dr. Flynn for a remarkably clear exposition of the inheritance factor in disease which he published in the *Australasian Medical Gazette* of 1901-1902. In the March issue (1901) he dealt with this subject of family diseases, and pointed out that the inheritance of these diseases by members of successive generations does not occur, partly because the diseases are usually already far advanced when the patients reach a marriageable age, and partly because they have undergone metamorphosis in transmission. He states that there is generally some evidence of nervous derangement or disorder in members of the previous generation. Moreover, when successive cases do occur, family diseases like Friedreich's ataxia are almost always passed on through the female side. The Polish pathologist, Higier, extended Apert's classification of inheritance of disease by recognizing a direct and a collateral form, and by subdividing the latter into mixed and pure forms. Conditions, such as hæmophilia, were regarded as instances of the pure form, and the inheritance passed through the female side to males, after affecting collaterals, nephews, cousins and brothers. In this connexion he pointed out that collateral or family degeneration is prevented from becoming a race degeneration by the mere fact that the affected individuals have no progeny. He had no hesitation in including in his list of inherited family organopathies Friedreich's ataxia. If the observed fact that Friedreich's disease occurs with marked frequency in several members of one family in a single generation, including collaterals who have not been in intimate contact with affected members, without having been present in any of the direct ancestors indicates that the disease must be a family disease—and we can see no escape from this conclusion—it is necessary to ascertain what it is that is inherited. In the family dealt with by Dr. Litchfield there were nine children, and of these two had undoubted Friedreich's ataxia, a third boy had ataxia, possibly of the same nature, while a fourth child was described as a "nervous boy." It is significant that no instances of other degenerative processes, such as Marie's cerebellar ataxia, amyotrophic lateral sclerosis or one of the cerebral diplegias was found in any of the children. It is difficult to reconcile the form of changes with the view that the tendency or predisposition to degenerative change is inherited. An inherited vulnerability of the posterior and lateral columns may, it is true, be handed on by neurodegenerate ancestors, and the determination of the form of disease may be produced in a slight disturbance of the blood supply of certain parts of these systems. We would then have a mixed form of collateral inheritance, a double form, firstly laying the foundation for degenerative changes on small provocation, and secondly producing an impairment of development of certain small vessels supplying the posterior regions of the spinal cord. If this reconciliation between the family predisposition and Williamson's theory of the origin of the disease be accepted, we should have an obvious explanation of the improvement effected by rest in the ataxic brother of the patient.

THE ANÆMIAS.

The term anæmia is glibly used by medical practitioners and by the public, and appears in many official documents in a connexion which does not admit of clear definition. To the public it probably means a "poorness" of blood which attacks the person as a result of some obscure change, and which can be remedied by the taking of a tonic. Many general practitioners, while realizing that there is a vast difference between pallor, oligochromæmia and oligocythæmia, and between primary anæmia and the secondary anæmias, use the term in so loose a manner that there is a strong tendency for them to adopt an unjustifiable and slipshod method of dealing with these important affections. It is common for a general practitioner to regard the differentiation of the various forms of anæmia as a task outside his purview, and to base his practice on the result of iron or arsenic on any condition characterized by pallor of the skin and mucus membranes and general debility. If the patient fails to improve

in response of these empirical remedies or even in spite of them, the consideration of some more serious affection impels him to send his patient to a pathologist to have his blood examined. The patient has no choice, notwithstanding the fact that he is required to pay the pathologist a fee for making a diagnosis which the general practitioner should have made when he first applied to the practitioner. In addition the patient may discover to his cost that a favourable time for the application of suitable remedies has passed, and that the delay due to the application of treatment on the basis of a guessed diagnosis has robbed him of his chances of recovery. Every practitioner is supposed to possess a microscope and some knowledge of the diseases he undertakes to treat. He also lays claim to the possession of God's most precious gift, intelligence. There is therefore no reason why he should not examine samples of blood from every patient in whom he has reason to suspect some blood change. A guess diagnosis of anæmia is unpermissible in these days, and should never be made. Iron should never be given unless the practitioner has definite proof that the anæmia is a true chlorosis and that the corpuscular elements are not affected by pathological influences. With a little practice, provided that the observer has familiarized himself with the appearances of normal and abnormal blood cells, the examination of a blood film can be effected in a very few minutes, and a complete count can be carried out in less time than the practitioner is willing to devote to a *causeric* with his patient. The patient has a right to demand of the practitioner who accepts fees from him that he shall employ the usual methods of arriving at a diagnosis. A practitioner who does not use his microscope in diagnosis is neglecting his duty almost as much as one who does not use a stethoscope, a clinical thermometer or chemical reagents in the examination of the urine.

In the differentiation between chlorosis, pernicious or essential anæmia, myeloid or splenic leucæmia, malaria, sarcomatosis, infective endocarditis and numerous other conditions clinically characterized by pallor, the practitioner will gain much information from the careful study of a properly prepared film, stained by Giemsa's, Leishman's or May-Grünwald's methods, or by Ehrlich's triacid solution. He should never neglect to look at the film in a fresh condition unstained, in order to ascertain whether the erythrocytes are evidently abnormal. Much time may be saved by an orientation gained by a preliminary examination of stained and unstained films. In order to determine whether the proportional relation between erythrocytes and leucocytes is disturbed, a cell count must be made. Here again practice and some intelligence are necessary, and as we have pointed out above, the time required for this duty to the patient can easily be saved by cutting short unnecessary conversation. It is a gross fallacy to attempt to shorten the process by limiting the count to 50 squares of the hæmocytometer. Time may be saved for the moment, but at the expense of accuracy, and the error which may be introduced as a result of laziness may be sufficient to lead to an incorrect estimation of the nature of the blood change or of the progress of a blood affection. The hæmoglobin estimation can be carried out in a matter of seconds by anyone who performs out this determination frequently. When the differential leucocyte count is required, factors which conduce to accuracy and rapidity of work are a good light, freedom from disturbance and a good film. General practitioners find it advisable to make the smear by the bed-side and to postpone the fixation, staining and examination until the day's work is finished and a quiet half of an hour can be secured for the purpose at home. In addition to the reasons given above in support of the contention that a practitioner who does not undertake the examination of the blood in a large number of conditions neglects his duty to his patient, it may be pointed out that the only certain means of diagnosing malaria is by the microscope, and that the introduction of this disease into Australia by returned soldiers from New Guinea renders it imperative that an eagle eye should be kept open for its detection in the interests of the community in general.

THE INVESTIGATION OF LIVING SUBSTANCE.

Investigation of the chemical properties of living matter has made little progress. It is not yet pos-

sible to detect the combinations present in the tissues, though the substances that can be extracted from the dead material are well known. Mankind awaits the genius who will select a path of inquiry leading to a greater accumulation of useful information. The study of the qualities of the bioplasm is at present restricted by the narrow range within which experiments may be made. Few substances can be added to a living cell to react with the cellular constituents without destroying the vitality. We may therefore welcome the presidential address delivered at Newcastle to the Section of Physiology of the British Association for the Advancement of Science by Professor A. R. Cushny, on the analysis of living matter through its reactions to poisons. The evidence which can be obtained by a consideration of the pharmacological action of drugs is only of a qualitative nature, but even this small advance in the chemistry of living substance is worthy of attention.

At times the chemical action of a drug is obvious. Acids, alkalis and precipitants of the proteins give rise to changes readily understood from acquaintance with their chemical characters. Other substances, as quinine and prussic acid, influence the activity of ferments. These drugs may be regarded as qualitative tests for the presence of ferments in cells. The changes that these drugs bring about in the functions of the cells may be interpreted by their inhibitory effects upon enzymes. Quinine may be used in certain concentrations as a specific test for oxidases. Formaldehyde unites easily with amino-groups, and its pharmacological action will reveal the presence of these radicles.

Hyoscyamine and adrenaline act upon substances in the nerve endings in peripheral structures. Both of these bodies are optically active. Their dextro-rotatory isomers have no influence upon nerve endings. It would thus appear that the substances in the neural end-organ which react with them are optically active. While most of the drugs which affect the peripheral terminations of nerves are lævo-rototary, the dextro- and lævo-camphors interact with those in heart muscle. The central nervous system is affected by both of the optical isomers of camphor and atropine, so that we may conclude that the anchoring compound is different from that in plain muscle. Curarine acts in small doses on the terminations of motor nerves in muscles and in larger doses upon the autonomic ganglia. Nicotine and its allies act upon the ganglia in minute doses and in large doses affect the motor endings. Other drugs occupy an intermediate position between these groups. It would seem as if some substance or radicle was common to the two structures. The exact position of the substance is still a matter of dispute. It was formerly located in the terminal nerve fibres, but evidence has been adduced to show that it lies beyond the nerve fibres. These drugs will produce their pharmacological action after degeneration of the nerve fibres and disappearance of the nervous end-organs.

Digitalis has an effect on the heart muscle and, in greater concentration, on the muscular walls of the blood-vessels. When it is remembered that these structures have a common developmental origin, the presence of a chemical substance common to both is possible. Digitalis also has been found clinically and experimentally to throw into action the cardiac inhibitory centre in the medulla. Aconitine also has an action on the heart muscle and on the vagal medullary centre. The saponins which are closely related in chemical constitution to the glucoides of digitalis react with cardiac muscle but not with the vagal centre. The reacting substance in the heart can respond to digitalis, aconite and the saponins, but that in the vagal centre is not affected by the saponins. The common reactions indicate a similarity in chemical properties of some components of these structures, while the distinctive effect of the saponins shows that the substances in the heart muscle and the vagal centre are not identical.

It must not, however, be supposed that chemical action alone is the basis of pharmacological influence. Dale has examined the action of tetramethyl-ammonium and tetræthyl-ammonium and shown that it is impossible to ascribe the differences in the effects of these bodies to differences in their reacting groups. Alterations in physical properties may also induce a change in function. The physical characters of the living cell may teach us something of the complex laboratory compressed in so limited a space.

THE ALLEGED STERILITY OF INTERNAL ORGANS.

Bacteria may be said to be the doing and the undoing of the animal organism. It has been shown on numerous occasions and under divers circumstances that no mammal or intervetebrate can continue to exist in an environment freed of parasitic life. In the case of some forms of living organisms a mutual form of parasiticism exists, and two organisms live on each other and perform certain functions in the service of the other. An instance of this double form of parasiticism is found in certain beetles, *Myrmedoniae* and *Lomechusae*, which are invariably accompanied by ants. Each is indispensable to the other; each may become intolerable to the other, and under given circumstances may annoy to an extent that the annoyed seeks to destroy the annoyer, and often succeeds. A chicken hatched in the absence of bacteria and fed on sterile food, kept in air filtered free of bacteria and housed on sterile sand dies after a varying number of days after an uneventful life unassociated with normal growth. On the other hand we are told that the body fluids are sterile under normal conditions. Lister attempted to prove this of urine, but his experiments have been criticised and challenged. Urologists still adhere to the assumption that the thesis which he endeavoured to prove was correct, but this opinion is based on weak evidence. Recent researches have brought to light facts which point to the existence of bacteria in the tissues of animal bodies, including those of man. To this evidence A. W. Sellards has contributed. In a communication to the American Society of Tropical Medicine he gave an account of the results of some experiments carried out with the spleens of ten

persons suffering from pernicious anæmia.[1] No bacteria were gathered from four of these spleens. Three yielded a micrococcus, with which we need not concern ourselves at present. In the remaining three spleens there was an anaerobic bacillus, which he was able to show was practically identical to Plotz's bacillus from the blood of persons suffering from typhus fever. Sellards carried out his cultural experiments with great care, and from his pure cultures tested the sugar reactions, and the agglutinating and complement fixation powers of his bacillus, comparing these qualities with those of Plotz's organism and of other organisms. He also investigated the cross fixation characters of the sera of rabbits immunized by these bacilli, utilizing both types or strains as antigen. All the evidence was in favour of a practical identity of the two bacilli. He argued that it was unlikely that one and the same organism could stand in a causal relation to two so dissimilar diseases as typhus fever and pernicious anæmia. The immunity reactions were of a kind to render it improbable that his bacillus was the cause of pernicious anæmia, and he found that it was questionable whether Plotz had made out a good case in favour of his bacillus being the cause of typhus. A more probable explanation, to his mind, of these findings was that this anaerobe was a parasite of the human body, but was non-pathogenic. The weakness of his argument is that the organism was derived in each instance from the spleen of a person suffering from pernicious anæmia. He admitted this defect, but pointed out that no opportunity had presented itself to him to obtain a normal spleen removed during life. A chance may occur which will give this opportunity to some surgeon. A spleen may be removed which on examination may prove to be normal, or at all events to be not associated with an infective process. If every spleen removed by operation could be handed to a competent bacteriologist on its removal, the point raised might be settled beyond speculation. In the absence of this crucial test, it certainly appears as if Sellards had isolated an organism which represents a member of the parasitic flora of the human body.

THE DIAGNOSIS OF RENAL TUBERCULOSIS.

It has long been felt a serious disadvantage that the confirmation of the diagnosis of tuberculosis by animal inoculation necessitates a delay of several weeks. The routine testing of milk for tubercle bacilli demands the injection of the centrifuged deposit into the subcutaneous or peritoneal tissues of a guinea-pig. The animals are usually killed after five or six weeks, and by this time tubercular lesions will be plainly discernible if the material inoculated contained tubercle bacilli. Various suggestions have been made from time to time in the endeavour to shorten this interval. Of these suggestions the most promising consists in the bruising of the inguinal lymphatic glands on the same side as the injection is made. Typical lesions may be found in these glands in about three weeks. Dr. John J. Morton has recently published an account of a method which promises to reduce the interval still further.[1] In 1914 Murphy and Ellis found that the susceptibility of white mice to bovine tubercle bacilli could be increased by the exposure of the animals to X-rays. Dr. Morton was concerned in an endeavour to expedite the diagnosis of renal tuberculosis by animal experimentation, and determined to apply this method to guinea-pigs. The detection of acid-fast bacilli in the urinary sediment is not sufficient evidence of tuberculosis on account of the possibility of contamination by smegma bacilli. It is therefore necessary to utilize guinea pigs for the ultimate diagnosis before operation. Guinea-pigs were exposed to one massive dose of Röentgen rays and given an injection of 1 c.cm. or 2 c.cm. of urine from a patient suffering from renal tuberculosis intraperitoneally after the exposure. Later he applied the radiation subsequently to the inoculation. In both cases the tubercular lesions developed within 8 to 10 days. The exposure was made by means of a Coolidge tube and was for a period of 10 minutes. The target was placed 12 inches distant from the cardboard box in which the guinea-pig was enclosed. A five milliampère current was passed through the tube. No filters were employed. The results in a small series of experiments were striking. In all cases the inoculation diagnosis was confirmed at a later date. The urine from a tubercular kidney produced well-marked tubercular lesions in the spleen, mesenteric lymphatic glands and liver. If these findings can be confirmed by other investigators, this method should find favour not only in urological practice but also in the diagnosis of other tubercular lesions and in the detection of tubercle bacilli in milk. Ellis and Murphy came to the conclusion that the increased susceptibility of white mice was effected by a destruction of lymphoid tissue. Morton found that one massive exposure of guinea-pigs to X-rays resulted in a reduction of leucocytes in the blood from 12,000 or 15,000 to 4,000 or 6,000 per cubic millimetre. The reduction mainly involved the lymphocytes. It is possible that the mechanism of the diminished resistance to the tubercular process may depend on an inhibited leucocytic activity, but more evidence is required before this assumption can be accepted. In the meantime the reliability of the method should be tested on a large scale.

[1] *New Orleans Medical and Surgical Journal*, January, 1915.

[1] *Journ. Experimental Medicine*, October 1, 1916.

Readers of *The Medical Journal of Australia* will notice that the name of a well-known firm—Messrs. H. B. Silberberg & Company, Limited—whose advertisements appear in our columns, has been changed to H. B. Selby & Company, Limited. We are assured that this firm has never employed any foreign capital, and that none of the shareholders are of enemy origin. The Managing Director's name was Silberberg; he has deemed it advisable to adopt the name of Selby for obvious reasons. Mr. Selby's grandfather was born in Poland; he came to Australia nearly 70 years ago. His father was a well-known Victorian.

A conference of medical practitioners and pharmacists of Victoria was held at the request of the Minister of Public Health on January 25 and February 1, 1917, for the purpose of considering the schedule of drugs which may be sold on the prescriptions of medical practitioners under the provisions of the Venereal Diseases Act, 1916. A report of the discussions will be published in next week's issue.

Abstracts from Current Medical Literature.

THERAPEUTICS.

(52) Serum Treatment of Poliomyelitis.

C. W. Wells (*Journ. Amer. Med. Association*, October 21, 1916) gives a brief report of the results of administering immune human serum in fifteen cases of anterior poliomyelitis. The human serum was obtained from ten donors by puncture of the median basilic vein. The blood was enclosed in sterile glass tubes until the serum separated. The serum was collected and stored at 36° F. until required. The ages of the donors varied from 7 to 44 years. In four cases the serum was taken two or three weeks after recovery, in two cases two years after the illness, in one case five and a half years later, in another case nine years later and in two cases 32 and 39 years after the attack of infantile paralysis. The amount of blood removed from each patient was sufficient to yield from 75 to 300 c.cm. of immune serum. Fifteen cases were treated during the early stages of the disease with 11 recoveries and four deaths. The serum was given by intraspinal, intravenous and intramuscular injection. When the serum was given by intravenous or intramuscular injection five cubic centimetres of cerebro-spinal fluid was removed at the same time by lumbar puncture. The doses given in the first cases treated were small, but when it had been found that no harmful effects followed the use of the serum the dose was increased to 70 c.cm. by intravenous injection. The author considers that the intravenous medication the most satisfactory, and he advises the use of injections of 50 or 100 c.cm. of convalescent serum. He says that a marked amelioration of the symptoms occurs after intravenous or intramuscular injections. This improvement is at times transient. The improvement after intraspinal injections is less noticeable. The two following histories illustrate the therapeutic action of the serum. The first symptoms had been observed in a girl aged 16 months, five days before the first injection. Paralysis of the arms and legs and of the external respiratory muscles was present. The respirations were irregular, shallow and entirely diaphragmatic. Cyanosis and dyspnœa were observed. The temperature was 103° F. Five cubic centimetres of serum were given intraspinally. The next day another dose of serum was given intraspinally along with 8 c.cm. by intravenous injection. The spinal fluid at the first injection contained many leucocytes, which steadily disappeared from the subsequent samples. After the second injection improvement was rapid. Recovery occurred despite the alarming appearance upon admission. In the second case the onset, in a boy aged 18 years, was attended with headache, fever and malaise. On the fifth day paralysis was observed in the left leg and right arm. The patient was admitted to hospital on the sixth day. He was delirious and semi-comatose, with spinal rigidity, with tenderness and pain in the neck, and with bilateral flaccid paralysis of arms and legs. The respirations were shallow. There was complete retention of urine. Small doses of serum were given daily for four days. The improvement after each injection was not sustained. On the eleventh day, as his condition was bad, he was given 25 c.cm. by intravenous injection. In four hours he had greatly improved. He ultimately recovered.

(53) Distribution of Iodine After Absorption.

D. Marine (*Journ. Biol. Chemistry*, November, 1915) has estimated the proportion of a dose of potassium or sodium iodide, given by the mouth to dogs, that is absorbed by the thyroid glands. He has carried out his experiments by removing one lobe of the thyroid gland aseptically. This lobe, which serves as a control, is weighed. This lobe is divided, one part being prepared for histological examination and the remaining part, which is dried, furnishes the material for the determination of the original content of iodine. Doses of 50 mg. of potassium or sodium iodide have been given to six dogs in daily amounts of 5 mg. on ten consecutive days. The remaining lobe of the thyroid gland is removed five to eight days after the last dose. It is weighed, divided, and treated in the same way as the control gland. The gain in iodine in the six cases has been pronounced, the quantity stored varying from 2.5 mg. to 5.4 mg. per gramme of dried gland. The iodine in the gland has been increased between seven and fifty times the amount originally present in the thyroid gland of the untreated dogs. The larger the weight of the remaining lobe of the thyroid gland the greater the amount of iodine stored within it. As much as 18.5% of the dose of iodide taken by the mouth has been recovered from a thyroid gland, whose ratio to the body weight is as 1 is to 687. The amount of iodine absorbed depends on the degree of saturation with iodine of the thyroid gland at the time of the administration of the iodide. The gland appears to take up iodine until it becomes saturated. The concentration with iodine, at the point of saturation is 5 or 6 mg. per gramme of dried thyroid material. The liver and spleen have been examined during these experiments for iodine, but with entirely negative results.

A further study by the same author, in collaboration with J. M. Rogoff, deals with the absorption of potassium iodide by the thyroid gland, following its intravenous injection in constant amounts (*Journ. of Pharmacology and Exper. Therapeutics*, August, 1916). Thirty-three experiments have been carried out on dogs. Under anæsthesia with ether, the renal vessels are ligated, and one lobe of the thyroid gland is removed. Fifty milligrammes of potassium iodide are injected into the jugular vein below the thyroid area. The remaining lobe of the thyroid gland is excised at intervals of time varying from five minutes to thirty hours after the injection. In some experiments the renal vessels have not been tied. The lobes of the thyroid gland are weighed, dried, and used for the estimation of iodine. The control thyroid glands have varied much in size, in content of iodine, and in physiological activity, as indicated by their histological appearances. The thyroid gland takes up iodine from the blood practically instantaneously. The absorption is so rapid during the first few minutes that any further absorption of iodine is masked. As the absorption is so fast ligature of the renal vessels has been omitted without altering the character of the results. The total amount absorbed has varied with the weight of the remaining portion of the gland, and the state of physiological activity. The glands appear to be saturated with iodine when they contain 7 mg. per gramme of dried tissue, The spleen and liver have been examined for iodine in all these experiments, but no iodine appears to be retained in these organs.

(54) Treatment of Carriers of Amœbic Dysentery.

H. H. Dale points out that the treatment of entamœbiasis in Great Britain is largely concerned with the problem of freeing "carriers" from their infection (*Journ. Roy. Army Med. Corps*, August, 1916). Experience has shown that the use of injections so successful in acute cases does not free the fæces of patients from the cysts of *E. histolytica*. The alleged superior efficacy of emetin given orally has led Dale to test the action of a double iodide of emetine and bismuth, which is free from the notorious drawbacks of the usual preparations containing emetin. By experiments on cats the dosage of this new compound was ascertained. Forty milligrammes produce no effects but a little looseness of the bowels. Sixty milligrammes give rise to vomiting about six hours after administration. This vomiting is ascribed to the action of emetin after absorption from the intestines, and is similar to that caused by emetin on injection. The compound is not soluble in acids, but is dissolved by alkalis. It is assumed that the emetin is not liberated until the drug reaches the intestines. Ten patients have been treated with doses of thirty grains, given in daily amounts of two to four grains. The results have been inspirating. Six patients have been cured. These cases have revealed no cysts in the fæces for six weeks. The fæces have been examined daily by a skilled protozoologist. In the remaining four cases the treatment is still being continued. The compound is being tested in cases of acute amœbic dysentery. Further reports are promised.

UROLOGY.

(55) Polycystic Disease of the Kidney.

W. F. Braasch publishes some clinical data concerning polycystic disease of the kidney, and illustrates his remarks by means of pyelograms (*Surg., Gynec. and Obstet.*, December, 1916). This condition occurs in three stages: (1) the latent stage in young adults; (2) the stage of renal tumour and hæmaturia occurring in persons of middle age, and (3) the uræmic stage. The latent stage is rarely discovered, save in the course of an abdominal exploratory operation. The surgeon is usually called upon to deal with the disease in the stage of renal tumour and hæmaturia. The subjective symptoms are pain, hæmaturia, tumour and symptoms resulting from diminished renal function. Braasch has found that the signs of renal insufficiency in polycystic kidneys differ from that occurring in nephritis. Nausea and vomiting were met with frequently, but in none of his cases did he see œdema of the extremities. When renal insufficiency is present or pending there may be polyuria, and the urine may have a low specific gravity. In regard to the phenolphthalein test the author calls attention to the fact that polycystic disease may be present when the secretion of this substance is normal, and when the specific gravity of the urine is normal. Pyelography assists the surgeon in making his diagnosis. The abnormalities may be characterized by flattening and obliteration of one or more major calyces; by retraction and broadening of the major calyces; by elongation or rounding of the pelvis, and by displacement of the pelvis from its usual position and angle. In 14 cases Braasch applied nephrectomy for the treatment of this condition. One patient died as the direct result of the operation. One died three years later of malignant disease. He was able to ascertain freedom from symptoms for periods varying between one and ten years in ten cases. In five cases an exploratory operation was performed. Some abdominal complication or evidence of renal insufficiency prevented any further operation in three of these patients. Polycystic disease of the kidney was discovered eight times during the course of operative treatment of other abdominal conditions. He performed Rovsing's operation on ten patients. Two patients died as a result of the operation, and one died three years later. Four of the remaining seven were operated on for persistent hæmaturia. In one patient the hæmaturia recurred two years after the operation. The disease was found four times in the post-mortem room. In 21 cases no operation was performed, on account of the existence of evidence pointing to involvement of both kidneys. In summing up, Braasch points out that marked clinical evidence of chronic toxæmia, a high blood pressure, and evidence of considerable renal disturbance should be regarded as signs of danger, and as indications that any operation would be of questionable value. When there is evidence of a moderate degree of renal insufficiency Rovsing's operation frequently produces considerable benefit. This operation should be undertaken to check otherwise uncontrollable hæmaturia, and also when large cysts are causing mechanical pressure on the adjacent tissues. Nephrectomy is indicated when there is widespread infection, persistent hæmaturia or destruction of renal tissue as a result of lithiasis, or other obstructive complications. The functional condition of the other kidney must be satisfactory before this operation is undertaken.

(56) Renal Calculi.

S. W. Schapira and J. Wittenberg enunciate three essentials for the formation of a renal calculus (*Urol. and Cutan. Review*, November, 1916). (1) Precipitated salts from which the stone is formed. (2) One or more nuclei about which the salts gather, and (3) a colloid matrix which binds the salts together. The usual salts are uric acid, urates, oxalates and phosphates. These salts precipitate when the reaction of the urine is unfavourable, when there is an excess of one salt, or a relative diminution of other salts. The nucleus may be a mass of ammonium urate, uric acid or calcium oxalate. Less frequently it is composed of pus, blood clot, epithelial cells or a broken tip of a catheter, or eggs of Bilharzia. The colloid forming the matrix is of the irreversable type, and cannot be redissolved after having been precipitated. The symptoms of renal calculi are local irritation by the stone, occasional renal colic, hæmorrhage due to mechanical injury, reflex symptom, tumour, pyuria and septic symptoms when secondary infection has occurred, and ultimately uræmia. The diagnosis should be made from the symptoms, and from the results of cystoscopic and radiographic examinations. In the treatment of renal calculi metabolism should be improved, and the diet should be carefully regulated; meat should be used moderately, epithelial organs like liver, kidney, etc., forbidden, fats used sparingly, and fruits and vegetables containing oxalic acid excluded. Diuretic drugs may be employed. Glycerine sometimes causes expulsion of small stones, while injection of oil into the ureter will frequently cause the expulsion of a stone low down in the ureter. For hæmorrhage he advises Basham's mixture, calcium lactate, and ergot. For anuria operation is the only possible treatment.

(57) Papilloma of the Bladder.

In a clinical lecture, H. H. Morton demonstrated the clinical diagnosis of vesicular papilloma in a man, aged 26 years (*Urol. and Cutan. Review*, November, 1916). For five years there had been hæmaturia. At times the urine was free from blood for some months. During the period when blood was passed micturition had become frequent. At times the stream of urine would be suddenly shut off. The patient complained of pain. A large round papilloma was seen through the cystoscope. The bladder was then opened, the pedicle seized with a Guyon forceps, and the latter was divided by the cautery. The author points out that bladder tumours are of two varieties, benign papilloma and carcinoma. The former extends and becomes multiple by contact inoculation. Cells are brushed off, are reimplanted on a fresh surface, and grow as a new tumour. Carcinoma, on the other hand, spreads by infiltration, by the passage of cells through the lymphatics or through the blood stream, and by metastasis. The chief symptom of bladder tumour is intermittent hæmaturia, and the diagnosis cannot be made with certainty without the aid of the cystoscope. The course of the disease may be slow or rapid, but every tumour of the bladder is potentially lethal. Sooner or later the papillomata undergo malignant degeneration, and it is therefore necessary to remove a benign tumour as soon as it is diagnosed. The ideal method of removing a papilloma is by fulguration. In regard to cancer of the bladder the author states that operative interference is only justified when the neoplasm involves the dome or front of the bladder, when budding growths clog the neck of the bladder and cause retention, or when the tumour gives rise to excessive bleeding.

(58) The Diagnosis of Renal Disease.

H. J. Whitacre (*Northwest Med.*, December, 1916) attempts to analyze the diagnostic signs of renal disease, and to give a guide for the recognition of various pathological processes. He reviews in turn the symptoms of pain, vesical irritability, fever, tumour, abnormal constituents in the urine, etc., and then turns his attention to the characteristic signs met with in calculi in the kidney and ureter, tuberculosis of the kidney, pyelitis, pyelonephritis, hydronephrosis, sarcoma and hypernephroma, acute unilateral nephritis, rupture of the kidney, acute septic infarct, congenital adhesions and perirenal adhesions. He concludes that pain is not to be relied on as a guide in diagnosis. Vesical symptoms frequently occur in renal disease, and should always induce the surgeon to seek for a renal cause. The endoscope and cystoscope are absolutely indispensable for the diagnosis of renal disease. On the other hand he is inclined to regard X-rays as far from unfailing as a diagnostic aid for renal or ureteral stone. The urine at times is apparently normal in the presence of renal disease. A continuous or intermittent fever without obvious cause should suggest pyelitis, even when no other symptoms than pyuria are present. Loss of weight and strength, associated with pyuria or hæmaturia may be regarded as evidence of renal tuberculosis. Many renal diseases at times fail to be distinguished by symptoms.

British Medical Association News.

SCIENTIFIC.

A meeting of the New South Wales Branch was held at the B.M.A. Building, 30-34 Elizabeth Street, on November 24, 1916, Dr. Sinclair Gillies, the President, in the chair.

Dr. Sinclair Gillies read some notes on a case diagnosed as *amyotonia congenita*, and demonstrated the patient.

Dr. W. F. Litchfield read a paper on the clinical record and family history of a case of *Friedreich's ataxia* in a child (see page 135).

Dr. Oliver Latham read his pathological report on the brain and spinal cord of the patient (see page 136).

Dr. A. W. Campbell discussed the clinical and pathological findings of the case, and commented on the ætiology of the condition (see page 138).

Dr. Sinclair Gillies raised the objection to Williamson's theory of the origin of Friedreich's disease that it did not explain in a satisfactory manner the age incidence and distribution. In a large number of cases the distribution and clinical picture were typical, and this fact was scarcely in consonance with the supposition that the toxin always started its attack in a particular area. He considered that the contribution of Doctors Litchfield, Latham and Campbell was a very valuable one.

Dr. John Flynn was not prepared to dismiss the hereditary theory of the origin of Friedreich's disease. He called attention to the fact that there was a marked difference between what was known as an hereditary disease and what had been termed a family disease. Hereditary diseases were passed on vertically, from generation to generation, while family diseases appeared laterally, in a single generation. Friedreich's disease attacked persons at the beginning of life, who did not survive to spread the disease to their progeny. The predisposing cause was not necessarily followed by the one symptom complex, and the hereditary parts of these diseases were manifested in various degenerations of the central nervous system. An exciting cause might affect several members of one generation in a family, but it would be unlikely that the same exciting cause would affect every member of one family.

In his reply to Dr. Gillies, Dr. Campbell stated that Williamson had advanced his views cautiously. Friedreich's disease arose at various ages, from five to twenty years. The distribution of the changes, too, varied very greatly, just as it did in other degenerative conditions. Similarly, the clinical picture varied. In some cases it had been reported that the anterior pyramidal tracts were affected, as well as the lateral and posterior columns. The onset of the symptoms frequently followed the same aberrant distribution.

Dr. W. F. Litchfield called attention to the fact that the case with which they had dealt would be the first one of its kind to be fully described in *The Medical Journal of Australia*.

Naval and Military.

It has been announced that Captain C. O. G. Donovan, R.A.M.C., who is serving with the Royal Lancashire Fusiliers, has been awarded the Distinguished Service Order. Captain Donovan left Australia in March, 1915, for the purpose of joining the Royal Army Medical Corps, and has been in France for over a year. He was wounded in November, 1916, and has been under treatment in England. We understand that he is now convalescent.

* * * * *

The 271st list of casualties was issued on February 8, 1917. We learn from it that Captain N. E. B. Kirkwood is ill in Hospital.

* * * * *

The announcement of the undermentioned appointments appears in the *Commonwealth Gazette* of February 8, 1917:—

Army Medical Corps.

Captain (temporary Major) V. Benjafield relinquished temporary rank of Major on demobilization of the personnel of the "Ras-el-Tin" Convalescent Depôt. Dated 4th October, 1916.

No. 1 Australian Dermatological Hospital.

Captain (temporary Major) T. F. Brown, D.S.O., retains temporary rank of Major whilst holding the appointment of Registrar. Dated 1st October, 1916.

Divisional Staffs.

Third Australian Division.

Major J. H. Anderson, from 7th Field Ambulance, to be Deputy Assistant Director Medical Services. Dated 27th September, 1916.

Public Health.

THE HEALTH OF AUSTRALIA.

Infective Diseases Notified in Australia during the Quarter ending December 30, 1916.

	N.S.W. Cases.	Vic. Cases.	Q'land. Cases.	S.A. Cases.	W.A. Cases.	Tas. Cases.	C'wealth. Cases.
Enteric Fever	282	64	206	85	66	1	704
Scarlatina ..	1,017	379	111	43	29	5	1,584
Diphtheria ..	887	1,184	365	174	151	28	2,789
Pul. T'b'c'losis	*365	455	124	136	102	32	—
C'bro-Sp. Men.	83	98	15	18	29	8	251
Poliomyelitis.	7	4	9	0	1	0	21
Malaria	6	0	28	0	2	0	36
Erysipelas ..	—	—	35	43	6	—	—
Puerp'l Fever	—	—	8	7	—	—	—
Septicæmia ..	—	—	—	—	6	—	—
Bilharziosis ..	—	—	—	—	2	—	—
Pyæmia	—	—	—	—	1	—	—
Beri-beri ..	—	—	—	—	3	—	—
Morbilli ..	—	—	—	1,059	—	—	—
Pertussis ..	—	—	—	765	—	—	—
Ophthalmia ..	—	—	—	—	2	1	—
Ankylost'm'sis	—	—	16	—	—	—	—
Varicella ..	—	—	99	—	—	—	—
Variola	1	0	0	0	0	0	1

The total number of notifications are not given for those diseases which are not notifiable in all the States.

* Notifiable only in portion of State.

NEW SOUTH WALES.

The following notifications have been received by the Department of Public Health, New South Wales, during the week ending February 3, 1917:—

	Metropolitan Combined District. Cs.	Dths.	Hunter River Combined District. Cs.	Dths.	Rest of State. Cs.	Dths.	Total. Cs.	Dths.
Enteric Fever ..	15	2	6	0	47	2	68	4
Scarlatina	27	0	2	0	10	0	39	0
Diphtheria	41	1	3	0	32	3	76	4
C'bro-Sp'l Menin.	0	0	0	0	3	0	3	0
Poliomyelitis ..	2	0	0	0	1	1	3	1
*Pul. Tuberculosis	32	13	1	0	0	2	33	15

* Notifiable only in the Metropolitan and Hunter River Districts, and, since October 2, 1916, in the Blue Mountain Shire and Katoomba Municipality.

THE HEALTH OF VICTORIA.

The following notifications have been received by the Department of Public Health, Victoria, during the week ending February 4, 1917:—

	Metropolitan. Cs.	Dths.	Rest of State. Cs.	Dths.	Total. Cs.	Dths.
Diphtheria	26	2	11	2	37	4
Scarlatina	4	0	3	0	7	0
Enteric Fever	8	0	12	3	20	3
Pulmonary Tuberculosis	21	8	11	4	32	12
C'bro-Spinal Meningitis	0	—	1	—	1	—

INFECTIVE DISEASES IN QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, during the week ending February 3, 1917:—

Disease.	No. of Cases.
Pulmonary Tuberculosis	6
Enteric Fever	27
Scarlatina	8
Diphtheria	16
Poliomyelitis	1
Malaria	4
Ankylostomiasis	1
Erysipelas	1

THE HEALTH OF WESTERN AUSTRALIA.

The following notifications have been received by the Department of Public Health during the month ended January 27, 1917:—

Disease.	Metropolitan. Cases.	Rest of State. Cases.	Totals. Cases.
Enteric Fever	18	15	23
*Diphtheria	55	16	71
Scarlatina	8	3	11
Pulmonary Tuberculosis	17	15	32
Septicæmia	2	0	2
Cerebro-spinal Meningitis	5	0	5
Erysipelas	1	2	3
Ophthalmia	3	0	3

* One case returned as membranous croup.

THE HEALTH OF TASMANIA.

The following notifications have been received by the Department of Public Health, Tasmania, during the week ending February 3, 1917:—

Disease.	Hobart. Cases.	Launceston. Cases.	Country. Cases.	Whole State. Cases.
Diphtheria	3	0	4	7
Enteric Fever	1	0	1	2
Pulmonary Tuberculosis	**2**	**1**	**2**	**5**
Scarlatina	0	0	1	1

INSANITY IN NEW SOUTH WALES.

The Inspector-General of the Insane (Dr. Eric Sinclair) has submitted to the Under-Secretary of the Department of Public Health his report on the state and condition of the hospitals and other institutions for the insane of the State of New South Wales for the year ending December 31, 1915.

The number of insane persons under official cognizance at the end of the year was 7,099, being 161 more than at the beginning of the year. This makes the proportion of insane among the general population 1 in 263. There were on the register 4,169 male and 2,930 female persons. Of the insane, 6,576 were in mental hospitals, 81 in licensed houses, 36 coming from the Broken Hill district, in Parkside Mental Hospital, South Australia, and 406 were absent upon leave under the provisions of the Lunacy Act. Of the patients in mental hospitals, 4,377 were inmates of the metropolitan institutions at Callan Park, Gladesville, Parramatta, and Rydalmere, while 2,199 were confined in the rural institutions at Kenmore, Newcastle, Morisset, Stockton and Rabbit Island. There were 52 inmates in the criminal section at Parramatta. The number of patients confined within the hospitals increased by 141 during the year. This increase is slightly less than the average for 20 years, which is 151. The number of admissions during the year was 1,346. The proportion of the number of admissions to the number of the general population is 1 in 1,388, which ratio represents "the occurring insanity." The number of patients who were admitted for the first time to an asylum in New South Wales was 1,120. The readmissions numbered 226. The admissions from places overseas amounted to 45. Of these 45 patients 22 were discharged within a few days. The number of persons who recovered was 568. The recovery rate based on the number of admissions for the year, is 42.2%. The number of those discharged relieved was 128, yielding a proportion to the number of admissions of 9.5%. The recovery rate is about 2.5% higher than the average rate for the last ten years. The number of patients granted leave of absence to the care of friends was 807, making with those on leave at the beginning of the year 1,193 upon probation. Of these patients, 323 were discharged, 450 were returned to hospital and 14 died. The number of patients remaining on probation is thus 406.

During the year 55 persons escaped from the mental hospitals. All were followed and, with four exceptions, returned to hospital in a short time. None of the four who were not retaken belonged to the dangerous class. The majority of those who attempted to escape were in the convalescent class, who were given much liberty to assist their cure. During the year 489 patients died, of whom 310 were men and 179 were women. The rate of mortality calculated on the average resident population is 73.9 per thousand. The cause of death in 217 cases was some lesion of the brain. Forty-nine deaths were attributed to consumption and 32 to pneumonia and bronchitis. Decay and old age accounted for 57 deaths and diseases of the cardio-vascular system for 44 deaths. Two patients committed suicide by hanging and one was found drowned under circumstances pointing to an accidental death. Two patients died as the result of accidental injuries. A coronial inquiry is held in every case of sudden death within the mental hospitals. In five cases the verdict was death from natural causes. The number of accidents leading to minor injuries was only 30.

The mental hospitals were overcrowded during the year. Permanent quarters were provided for 5,460 inmates, while 6,576 patients required accommodation. The transference of 536 patients to Stockton, Rabbit Island and Morisset relieved the strain, but 586 patients had to sleep on the floors and verandahs and in rooms and corridors designed for other than sleeping purposes. It was hoped that additional wards would be built at Morisset and Stockton in 1916 to cope with the condition of overcrowding.

The Reception Houses at Darlinghurst and Newcastle received 1,496 persons. Of these 593 were discharged. These persons were not certified as insane and were not removed to mental hospitals. These institutions served the useful purpose of accommodating patients suffering from attacks of mental disorder which might be rapidly relieved. To these wards were admitted patients suffering from alcoholism. These patients were unfitted for treatment in mental hospitals. It is most advantageous to the community that persons suffering from mental diseases of an acute character with little tendency to become chronic, should be sent for adequate treatment to these Reception Houses. An expert staff is available for treatment, and every opportunity is afforded for the cure of the patients without attaching to them the stigmata of insanity.

A table classifying the causes of insanity among the patients admitted during the year 1915 is appended to the report. The ætiological factors were grouped as predisposing and as exciting causes. Among predisposing factors previous attacks were entered 185 times. Hereditary influences were ascertained as contributing to insanity in 113 patients, and some congenital developmental defect was present in 182 persons. Chronic ill-health was considered a predisposing cause in 72 cases, and old age in 52 persons. Among the exciting causes for the attack of insanity alcoholic excess appeared to initiate the disorder in 208 persons. Venereal disease produced insanity in 87 patients. Twenty-six cases of puerperal insanity were dealt with. Epilepsy was noted on 67 occasions. Chronic ill-health lead to insanity in 57 patients. Among moral or mental factors, domestic troubles brought about mental disease in 42 cases, business anxiety and pecuniary difficulties caused an attack in 43 persons, and "worry" and overwork in 63 patients. In 371 persons no cause, predisposing or exciting, could be discovered.

An interesting table gives the ages of the patients admitted, of the patients who are no longer under treatment, and of those under control in the mental hospitals. Of the 8,555 patients under control during the year, 482 were under

20 years of age, 1,281 were between 20 and 30 years old, 1,873 between 30 and 40 years, 1,907 between 40 and 50 years, 1,667 between 50 and 60 years, 863 between 60 and 70 years, 385 between 70 and 80 years, 87 between 80 and 90 years, and 8 over 90 years old. Of 1,346 persons admitted in the year, 118 were under 20 years of age, 273 were between 20 and 30 years old, 321 between 30 and 40 years, 262 between 40 and 50 years, 200 between 50 and 60 years, 96 between 60 and 70 years, 64 between 70 and 80 years, 11 between 80 and 90 years, and 1 over 90 years old. These figures show that the inmates of mental hospitals live at least to the same age as the average member of the general population. As the death-rate in the hospitals is greater than in the general population, it follows that the average age of patients at admission is greater than the average age of the members of the community. It is probable that many young children afflicted with mental disease die without being certified as insane. The average age of the insane ascertained from the ages of those certified appears therefore too high.

A table shows the forms of mental diseases from which patients were suffering upon admission. One hundred and eight persons exhibited symptoms of congenital or infantile mental deficiency which was associated with epilepsy in 32 cases. Epileptic insanity was present in 71 patients, and general paralysis of the insane in 83 persons. Mania was diagnosed on 558 occasions. Acute mania was present in 141 persons, delusional mania in 235, mania *a potû* in 107, recurrent mania in 39, senile mania in 19, and puerperal mania in 13 persons. Melancholia was present in 312 patients. Delusional mania was the most common form, being found in 197 patients. Acute melancholia occurred 85 times, and puerperal melancholia 5 times. Dementia was found in 213 patients. The senile variety occurred in 93 persons, primary dementia in 71 persons, and organic dementia secondary to tumour or some other kind of coarse brain disease in 37 patients.

The maintenance of the patients in the mental hospitals cost £268,795, being an increase of £18,963 on the amount expended in 1914. The average annual cost of each patient was £41 1s 10d, being £2 5s 5d more than in 1914. A comparison of the annual amount expended on each patient in each year since 1906 gives some useful information on the cost of living. In 1906 it cost just £28 to maintain a patient. The amount increased slowly to 1911, when it increased rapidly. Against the expenditure, the Master-in-Lunacy collected £44,702, so that the actual expenditure by the State was £220,033. In addition to this expenditure £16,794 were spent on other outlays not directly chargeable against the maintenance of the patients. The higher cost of commodities is well evidenced by the increased expenditure on this item, which was £15,000 on a previous expenditure of £60,000. The farms and gardens in connection with the institutions returned produce worth the handsome sum of £13,134.

The Inspector-General again draws attention to the need for amendment of the Lunacy Act. A Bill has been submitted to Parliament which contains provisions for the control of insane patients under care outside mental hospitals and licensed institutions, and regulations for the admission of voluntary patients into the mental hospitals. During the year voluntary patients have been admitted for treatment into the mental hospitals, thus anticipating the provisions of the Amending Act. Voluntary patients are admitted at their own request, and agree to abide by the rules of the hospitals, but they are free to leave when they wish. Patients who can recognize their own mental symptoms benefit by such a system, as they receive expert treatment in the incipient stages of their malady. This treatment probably will prevent their condition from becoming chronic.

Arrangements were made in the year for treating soldiers, returning from active service, with nervous and mental affections. The system adopted has obviated the necessity for certification. As the military authorities have power to detain soldiers in hospitals no further legal power is required to permit of control in mental hospitals. A special hospital was formed in the grounds of Callan Park Mental Hospital for these patients, who received the advice of two expert medical officers of the Department.

Vital Statistics.

SOUTH AUSTRALIA.

The returns of the births and deaths registered during the month of December, 1916, in South Australia have been published in the *South Australian Government Gazette* of January 18, 1917. The calculations are made on the estimated population of 441,690. The number of births registered was 837. This number is lower than the average of that registered in the same month of the preceding five years. The birth-rate works out at 22.68, when expressed as an annual rate. The equivalent rates for December of the previous five years average 26.54.

There were 325 deaths registered in the State in December, 1916. The death-rate is equivalent to an annual rate of 8.88 per 1,000 of population. The average rate for December of the previous five years was 11.38. The infantile death-rate was 40.6 per 1,000 births.

In regard to the causes of death affections of the cardio-vascular system as usual come first. There were 53 deaths in this category, including 41 from chronic heart disease and 10 from cerebral hæmorrhage. Infective processes caused 100 deaths, if the following are all included. Tuberculosis was fatal 25 times, diarrhœa and enteritis 23 times, pneumonia 13 times, bronchitis 10 times, meningitis 7 times, pertussis 4 times, acute rheumatism three times, enteric fever and influenza, pleurisy, acute endocarditis and puerperal septicæmia twice each, and diphtheria, non-puerperal septicæmia, tetanus and acute nephritis once each.

There were 32 deaths due to malignant disease.

The returns for Adelaide contain the following information. There were 105 births, which, on the basis of a population of 43,743, yields a birth-rate equivalent to an annual rate of 28.8 per 1,000 of population. The birth-rate is higher than that recorded in December of the preceding five years. The number of deaths registered, excluding those which took place in public institutions of persons not usually resident in the city, was 50. The equivalent annual death-rate was therefore 13.68 per 1,000 of population. Three infants under one year of age died. The causes of death are given in tabular form. Since the numbers are small, these monthly returns do not give a reliable impression of the frequency of the various forms of fatal disease.

BRISBANE.

The Government Statistician has published his report on the vital statistics of Greater Brisbane for the month of December, 1916, and appends a summary for the complete year, which is subject to slight alterations. During the month of December 460 births were registered in the metropolitan area. The birth-rate calculated on an estimated population of 161,938 is equivalent to an annual birth-rate of 34.08. There were 30 illegitimate births, which yields an illegitimate birth-rate equivalent to an annual rate of 2.22 per 1,000 of population. In the corresponding month of the previous year there were 22 births less than the month under review.

The number of deaths registered in December was 179. The death-rate was therefore equivalent to an annual rate of 13.44. It is noteworthy that the death-rate in the city is nearly four times that in the suburbs. In the corresponding month of 1915 246 deaths were registered. There were 35 deaths of infants under one year of age. The infantile death-rate was therefore 78.08 per 1,000 births. In December, 1915, 63 infants under one year of age died. During the month 69 deaths took place in the hospitals and public institutions.

The causes of death include 31 due to diseases of the cardio-vascular system, 17 of which were due to organic diseases of the heart, and nine to cerebral hæmorrhage. Of the infective diseases tuberculosis was responsible for 16 deaths, diarrhœa and enteritis for 15, epidemic cerebro-spinal meningitis for 4, morbilli for 3, lobar pneumonia for 2, broncho-pneumonia for 2, enteric fever, malaria, pertussis, influenza, dysentery, acute rheumatism, acute endocarditis, acute bronchitis and puerperal septicæmia for one each. One death is ascribed to congestion of the lungs, by which is probably meant pneumonia. There

were 14 deaths from cancer, 15 from Bright's disease, two from diabetes, eight from the various disease of the central nervous system, and one from alcoholism. Three deaths are attributed to anæmia without further information as to the form of disease.

In the summary for the year the following information is contained: There were 5,286 births registered in the metropolitan area, and the birth-rate was therefore 32.64 per 1,000 of population. In the year 1915 the birth-rate was 35.54. In 1916 there were 2,284 deaths registered. The death-rate was therefore 14.10 per 1,000 of population. In 1915 it was 13.48. Of the 2,284 deaths 439 were of infants under one year of age. The infantile mortality was therefore 83 per 1,000 births, which is 15% higher than the infantile mortality of 1915.

There were 420 deaths due to disease of the heart and of the vascular system. This represents over 18% of the total number of deaths. The infective diseases caused 802 deaths, including 219 from diarrhœa and enteritis, 159 from tuberculosis, 67 from morbilli, 60 from lobar pneumonia, 55 from broncho-pneumonia, 40 from epidemic cerebro-spinal meningitis, 21 from acute bronchitis, the same number from pertussis and also from diphtheria, including one entered as croup, 20 from syphilis, 20 from acute endocarditis, 18 from enteric fever, 14 from acute rheumatism, 14 from dengue, 13 from influenza, 12 from acute nephritis, 6 from tetanus, 6 from puerperal septicæmia, 5 from dysentery, 4 from erysipelas, 4 from non-puerperal septicæmia, and one each from malaria, scarlatina and pericarditis.

There were 180 deaths from cancer. The malignant growth was said to be situated in the liver 56 times (this is probably an error, and should have been "stomach and liver"), in the female genital organs 24 times, in the mouth 22 times, in the peritoneum and intestines 21 times, in the breast 17 times, and in the skin 11 times. Bright's disease killed 119 persons, diabetes 14, anæmia (?) 13 times, leucæmia 3 times, and exophthalmic goitre 4 times. There were 11 deaths from alcoholism, 7 from lead poisoning, and 15 from cirrhosis of the liver. The number of deaths associated with the puerperal condition was 31, and included 10 of puerperal albuminuria and eclampsia, in addition to the 6 cases of puerperal septicæmia referred to above. There were 110 deaths due to congenital debility, prematurity, etc., and 31 due to diseases peculiar to infancy. In 126 cases death was due to violence. There were 27 suicides, four cases of murder, four of sunstroke, and 86 of accident.

Correspondence.

"LITTLE LATIN AND LESS GREEK."

Sir,—It has been stated at times in recent years that "Little Latin and less Greek" suffices in the education of a person destined to be given the right to practice medicine and surgery.

In a certificate presented to me for verification a few days ago the following words were written: "Is suffering from intermittent taxicardia." It is well that the certificate bore upon the competency of the patient to drive a taxicab.

Yours, etc.,

JOHN B. NASH.

219 Macquarie Street, Sydney,
February 7, 1917.

RESECTION FOR INTUSSUSCEPTION.

Sir,—In the issue of the *Journal* of January 13, 1917, there is the report of a case of "Resection of an Intussusception in a child of 7 months with Recovery," by Dr. P. L. Hipsley. in view of the rarity of recovery after resection for intussusception in children under 12 months I wish to add another to the list published by Dr. Hipsley. This is the case of a child aged 6 months, operated on in the Royal Prince Alfred Hospital on November 16, 1912. The history was as follows: For a week previous to admission the child had been vomiting after each feeding, and had intermittent pains in the abdomen. The abdomen had gradually distended, and on the day of admission the child passed some blood by the rectum. An elongated abdominal tumour could be felt without difficulty. An olive oil enema given under anæsthesia failed to reduce the tumour. After the abdomen had been opened the intussusception was reduced without difficulty up to the last couple of inches, which consisted of ileum prolapsed into colon. Efforts failed to move this part, so the caecum, appendix and terminal ileum were removed, and a lateral anastomosis done between ileum and ascending colon. The child made a good recovery. In addition to those cases quoted from the literature by Dr. Hipsley, two other successful cases have been reported. The first is the resection of one-third of the colon for irremediable intussusception in an infant five days old, with recovery, by Charles N. Dowd, described in the *Annals of Surgery*, May, 1913, and the second is a successful case of resection of fifteen inches of intestine for ileo-colic intussusception in a child of six months, reported by Gerald S. Hughes, in the *Lancet*, September 23, 1912, p. 879.

Yours, etc.,

JOHN L. McKELVEY.

171 Macquarie Street, Sydney.
February 8, 1917.

THE WALTER AND ELIZA HALL INSTITUTE OF RESEARCH IN PATHOLOGY AND MEDICINE.

Sir,—The article headed "No Australian Need Apply" in your issue of February 10 is based on imperfect knowledge of facts. Arrangements were made through the Agent-General for Victoria to invite applications in London for the office of Director of the Walter and Eliza Hall Institute. A closely corresponding date was fixed for inviting applications in Australasia, and advertisements were in readiness for insertion in *The Medical Journal of Australia* and other journals in the several States and in New Zealand. Three days before that date the Agent-General forwarded by cable an important communication, urging that no appointment be made till the end of the war. The matter was considered by the Board of the Institute and referred to the Walter and Eliza Hall Trustees, as the Board was bound under the Trust Deed to have the Institute in full working order on October 1, 1917. After receiving a generous reply from the Trustees, the Board cabled to the Agent-General to postpone all further action concerning the appointment.

It is to be regretted that an article such as that in your last issue was published without enquiry.

Yours, etc.,

H. B. ALLEN,
Hon. Acting Director.

Melbourne University,
February 10, 1917.

[The information contained in Professor Sir Harry Allen's letter that the appointment of a Director of the Walter and Eliza Hall Institute of Research in Pathology and Medicine has been deferred is eminently satisfactory. Had this information been made public before or at the same time as the English journals containing the advertisement and editorial notices dealing with its contents reached Australia those who watch the development of Australian interests would not have had cause to look askance. It must be remembered that preference has been given on many occasions in the past to British applicants for Australian positions.]

THE MEDICAL PROFESSION AND THE FRIENDLY SOCIETIES.

Sir,—"Medico" wishes the lodge surgeons of Victoria to wait till the end of the war even though the framers of the original truce specially altered the phraseology from "duration of war" to "for the present." He must understand that our truce does not last till the war is over.

He asks for more organization so that when the war is over we will not have to wait "six months more, holding conferences, etc." Cannot "Medico" see that when the war is over, it will take many years before we will be in a position of secure organization.

For instance, the post bellum depression will be on us, the returned soldier will be out of work, the financial burdens on the community will be heavy, there will be whole-

sale adjustments of conditions of trade, finance, capital and labour.

Our own organization will have to organize the recent graduate who went to fight, the man who was, before the war, a locum or an assistant, or a hospital resident. We will have to organize the English doctors who, finding things bad in England, will emigrate to the colonies in large numbers, for as we are aware, medical men have been rushed through to meet the war's demands. There will be the French doctor also to organize, and possibly, the German, for should we have to fight the lodges they would not hesitate to employ this labour. Surely "Medico" does not think six months would be enough—rather six years. He sets up a wail: "Couldn't we get the Trades Hall to tell us what to do?" No use asking that body, it is doing now what I suggest. Go right ahead and ask yourself, "If you don't help yourself, don't expect others to advise or help you."

"Medico" says we should have the New Zealand men with us. This is really laughable. The New Zealand men right in the middle of the war, 12 months ago, struck for 30s. a year in peace, but 21s. during the war, and have won their fight. This is a better agreement than the N.S.W. model lodge agreement. Fancy inviting Napoleons like them to come in with Rip Van Winkles like us!

Yours, etc.,

D. ROSENBERG.

Richmond, Victoria,
February 10, 1917.

Proceedings of the Australasian Medical Boards.

QUEENSLAND.

The following have been registered under the provisions of the "Medical Act of 1867" as duly qualified medical practitioners:—

Allan, Robert Marshall, Brisbane, M.D., Univ. Edin., 1914.
Brent, Lindsay Peregrine, Brisbane Hospital, M.B., Ch.B., Univ. Melb., 1916.
Dean, Arthur William, Rockhampton, M.B., Ch.M., Univ. Syd., 1916.
Hart, John Wesley, Emerald, M.B., Ch.M., 1899, M.D., Univ. Edin., 1898.
Sanderson, John Murray, Thursday Island, L.S.A., Lond., 1898.

At the moment of going to press the news of the death of Lieutenant-Colonel J. F. Flashman reached Sydney. It is stated that he died of pneumonia.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xvii.

Brisbane Hospital, Junior Resident Medical Officers.

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
VICTORIA. (Hon. Sec., Medical Society Hall, East Melbourne.)	Brunswick Medical Institute. Bendigo Medical Institute. Prahran United F.S. Dispensary. Australian Prudential Association Proprietary, Limited. National Provident Association. Life Insurance Company of Australia, Limited. Mutual National Provident Club.
SOUTH AUSTRALIA. (Hon. Sec., 3 North Terrace, Adelaide.)	The F.S. Medical Assoc., Incorp., Adelaide.
QUEENSLAND. (Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.)	Brisbane United F.S. Institute.
WESTERN AUSTRALIA. (Hon. Sec., 230 St. George's Terrace, Perth.)	Swan District Medical Officer. All Contract Practice Appointments in Western Australia.
NEW SOUTH WALES. (Hon. Sec., 30-34 Elizabeth Street, Sydney.)	Department of Public Instruction—Appointments as Salaried Medical Officers, with duties which include the treatment of school children. Australian Natives' Association. Balmain United F.S. Dispensary. Canterbury United F.S. Dispensary. Leichhardt and Petersham Dispensary. M.U. Oddfellows' Med. Inst., Elizabeth Street, Sydney. Marrickville United F.S. Dispensary. N.S.W. Ambulance Association and Transport Brigade. North Sydney United F.S. People's Prudential Benefit Society. Phœnix Mutual Provident Society. F.S. Lodges at Casino. F.S. Lodges at Lithgow. F.S. Lodges at Orange. F.S. Lodges at Parramatta, Penrith, Auburn, and Lidcombe. Newcastle Collieries — Killingworth, Seaham Nos. 1 and 2, West Wallsend.
NEW ZEALAND: WELLINGTON DIVISION. (Hon. Sec., Wellington.)	F.S. Lodges, Wellington, N.Z.

Diary for the Month.

Feb. 20.—N.S.W. Branch, B.M.A., Executive and Finance Committee.
Feb. 22.—S. Aust. Branch, B.M.A., Branch.
Feb. 27.—N.S.W. Branch, B.M.A., Medical Politics Committee; Organization and Science Committee.
Feb. 28.—Vic. Branch, B.M.A., Council.
Mar. 2.—Q. Branch, B.M.A., Branch.
Mar. 7.—Vic. Branch, B.M.A., Branch.
Mar. 9.—S. Aust. Branch, B.M.A., Council.
Mar. 13.—N.S.W. Branch, B.M.A., Ethics Committee.
Mar. 13.—Tas. Branch, B.M.A., Council and Branch.
Mar. 15.—Vic. Branch, B.M.A., Council.
Mar. 15.—N.S.W. Branch, B.M.A., last day for Nomination of Candidates for Election of Council of Branch.
Mar. 16.—Q. Branch, B.M.A., Council.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.

All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney, New South Wales.